Screening Coordinator:

Name _____
Address _____
City _____ State ____ Zip _____
Phone (406) _____

Screening Date _____ / _____ / _____

School _____ City _____ County _____

MONTANA
Department of Public Health & Human Services

School Oral Health Screening Form

Please send copies to:
MT DPHHS - Oral Health
Family & Community Health Bureau
1218 E 6th Ave
Helena, MT 59602 (406) 444-0276

Screener: ☐ Dentist ☐ Nurse ☐ Dental Hygienist ☐ Other

Did Screener Complete Basic Screening Survey Training? ☐ Yes Mo/Yr _____ / _____ ☐ No

Name / ID Number	Grade	Age	Gender		Race/ Ethnicity	Untreated Cavities		Caries Experience		Sealants on Adult Molars		Treatment Urgency			Identify Problem
			M	F	*	Y	N	Y	N	Y	N	No	Early	Urgent	

*KEY

Race / Ethnicity
W =White
B =Black/African American
H =Hispanic/Latino
A =Asian
AI =American Indian/Alaska Native
NH =Native Hawaiian/Pacific Islander
MR =Multi-racial
U =Unknown

Untreated Cavities (Caries)
Yes = Decay present
(>.5 mm or 1/2 mm & brown)
No = No decay present

Caries Experience
Yes =
-Has decay &/or
-Has filling or crown &/or
-Had adult molar extracted due to decay
No =
-No decay &/or
-No fillings &/or
-No adult molar extracted due to decay

Sealants
Yes = One or more sealants on permanent molars present
No = No sealant present

Treatment Urgency
No = No Obvious Need
Early = Early Care Needed
Urgent = Urgent Care Needed